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Youth with Conduct Disorder

What is to be done?

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What is to be done?

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Youth with Conduct Disorder:

What is to be Done?*

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* This publication is based on a retreat held on March 7 - 9, 1990, at Eaton Hall, Seneca College in King City, Ontario. The retreat brought together researchers and clinicians in order to focus on the issues concerning youth with Conduct Disorder.

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INTRODUCTION

Conduct Disorder is one of the most common psychiatric disorders in children and adolescents between the ages of four and sixteen. It is distinguished by a persistent pattern of behaviour in which the basic rights of others and major age-appropriate societal norms are violated. Conduct Disorder is a serious diagnosis. Some studies demonstrate that up to 40 percent of those who received a child diagnosis of Conduct Disorder continue to have serious psychosocial disturbances in adulthood (Robins, 1970; Rutter & Giller, 1983). Moreover, parental antisocial behaviour appears to predict similar behaviour in one's off-spring (Robins & Earls, 1986).

The prevalence rate of Conduct Disorder reveals some alarming numbers. In Kazdin's (1987) review of treatment for antisocial behaviour he reported that between one-third and one-half of all child and adolescent clinical referrals involved antisocial behaviour, aggressiveness and conduct problems. Rutter et al. (1970) found that in the Isle of Wight community survey, over 3 percent of 10-year-olds had Conduct Disorder and almost three-

quarters of all boys and one-third of all girls considered to be psychiatrically disturbed were diagnosed as having the disorder. Similar rates have been found in Australia, 6.7 percent of 10-year-olds (Connell et al., 1982), and in New Zealand, 6.9 percent of 7-year-olds (McGee et al., 1984). Offord et al. (1988) found that the 1983 Ontario prevalence rate of Conduct Disorder among those 4 to 16 years of age was 5.5 percent. This meant that there were approximately 100,000 cases of Conduct Disorder in the province of Ontario at the time of the study.

Conduct Disorder exacts a heavy social toll on society. The disorder translates into impaired functioning in the classroom, in the home and with peers. As violating basic rights of others is both a key diagnostic criterion for Conduct Disorder and the basis for many actions which society considers criminal, many Conduct Disordered youth are involved with the law. While no specific cost figures for Conduct Disorder are available, in Canada a Solicitor General report (1988) indicated that the total cost at the institutional level per adult offender per year was $42,695 in 1986/1987. In Ontario, the 1986/87 per diem rate for incarcerating an individual was $101.89 (Ministry of Correctional Services, 1987).

The Rand Corporation (Greenwood, 1987) reported that in the United States, the expected crime and correction costs for one chronic juvenile offender were $225,000 to $350,000 over his or her life, based on 1.5 arrests per year over 13.3 years of crime. This figure does not include the cost of the damage done to other people's property. Besides the economic cost, there is the suffering of the families and the victims. There is also the waste of a young person's life who spends most of the time in and out of institutions instead of realizing his/her potential.

There are many good reasons why we should help Conduct Disordered youth specifically. As most of these young people have no serious disabilities and are of average intelligence, they have the potential to grow up to become normal adults. Moreover, these youth are typically victims of their experiences in early childhood, with some so seriously emotionally damaged that they are unable to straighten themselves out without help. By not taking steps to prevent the early damage and by not treating them afterwards, we condemn ourselves to bear the cost of looking after Conduct Disordered youth for most of their lives, and condemn them to a life of crime and despondency. Thus, the financial and social costs

associated with Conduct Disorder lead one to ask what more can be done to improve our programs.

Jalal Shamsie

Conduct Disorder - A Review

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LITERATURE REVIEW

The following review includes many studies based on delinquent populations, who may or may not have met the diagnostic criteria for Conduct Disorder.

DEFINITION

Conduct Disorder is one of the subclasses of Disruptive Behaviour Disorder which the DSM-III-R (American Psychiatric Association, 1987) identifies as "behavior that is socially disruptive and is often more distressing to others than to the people with the disorders." Typically, the majority of "hard to serve" cases belong in this diagnostic category, where the youth may have:

- stolen without confrontation of a victim on more than one occasion (including forgery)
- run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning)
- often lied (other than to avoid physical or sexual abuse)
- deliberately engaged in fire-setting
- often been truant from school (for older person, absent from work)
- broken into someone else's house, building or car
- deliberately destroyed others' property (other than by fire-setting)
- been physically cruel to animals
- forced someone into sexual activity with him or her
- used a weapon in more than one fight
- initiated physical fights

- stolen with confrontation of a victim (e.g., mugging, purse-snatching, extortion, armed robbery)
- been physically cruel to people

A Conduct Disorder diagnosis requires that three of these symptoms be present for a minimum of six months.

What is the central problem of children suffering from Conduct Disorder? Some argue that at the heart is:

> alienation from conventional values...of which behavior problems is only one piece of the evidence. But the case can also be argued the other way: the hostility toward conventional social values might be the expectable consequence of repeated confrontations between the disturbed child and authority figures (Robins, in press).

However, this explanation prompts the question of why these children do not adopt conventional values when the vast majority of their peers grow up embracing social norms. Adopting social norms is a learned process. There are many reasons why a child may fail to learn the social norms. Most of the time these reasons reside in the type of the family in which he or she grows up.

In some families children are unable to learn the societal norms, although the parents practice them, because of the lack of a warm, meaningful and confiding relationship with either parent, and inconsistent discipline.

In other families, children learn what a family has to teach them, but what is taught is socially undesirable. In these families disagreement leads to violence. Those who have the power, abuse it. There is constant fighting and verbal abuse. A child growing up in such a family learns to use aggression as a means to achieve the goals.

DIAGNOSIS OF CONDUCT DISORDER

Children who exhibit antisocial behaviour as their primary problem tend to fall under three subclasses of Disruptive Behaviour Disorders: Oppositional Defiant Disorder, Attention-Deficit Hyperactivity Disorder (ADHD) and Conduct Disorder (American Psychiatric Association, 1987). The fact these three subclasses are grouped together under Disruptive Behaviour Disorder suggests that they have the commonality of disruptiveness, characterized as being more distressing to others than to those with the disorder.

From the clinical evidence, it is also clear that these disorders may transform from one to the other. This usually happens in a particular order. Given the chain of progression from ADHD to Oppositional Defiant Disorder to Conduct Disorder and to antisocial personality, Robins (in press) queries whether one should

consider each of these as separate disorders or whether Conduct Disorder might be better seen as "the middle phase of a very chronic psychiatric disorder which typically begins early in life and continues into adulthood but which can also abort at any point along the way."

There has been a change in the subtyping of Conduct Disorder from the DSM-III to the DSM-III-R. The differentiation between socialized and undersocialized has been discarded in the latter. The DSM-III-R suggests that three subtypes exist:

-Group - predominance of conduct problems occuring mainly as a group activity with peers. Aggressive physical behaviour may or may not be present.

-Solitary Aggressive - predominance of physical aggressive behaviour is initiated by the person.

-Undifferentiated - differentiation between group and solitary types cannot be made.

The classification of Conduct Disorder along a single bipolar dimension has been suggested by Loeber and Schmaling (1985). Here, confrontive behaviours (fighting, temper tantrums) are found at one extreme and concealed behaviours (stealing, lying) at the

other. Children could be subtyped overt, covert or a combination of both types of symptoms. Kazdin (1987a) claims that while the diagnosis of Conduct Disorder can be broadly applied, greater specificity of the subtypes of behaviours would be beneficial in understanding antisocial behaviour.

ASSESSMENT OF CONDUCT DISORDER

There are four common ways of assessing children with conduct problems.

1. Behavioural Checklists: many behavioural checklists exist; some designed for teachers to complete such as the Revised Behavioral Problem Checklist and others designed for parents (Child Behaviour Checklist). Agreement between parents and teachers on checklist ratings is of greater prognostic value than the teacher's assessments alone (Mitchell & Rosa, 1979). However, many clinicians do not use checklists which are more commonly used in pharmacological and psychological research.
2. Psychiatric Interviews: in these interviews, the investigator asks questions on a whole range of subjects but is free to delve into certain areas as they come up. This interview

technique is typified by Rutter et al. (1981).

3. Interviews Based on Diagnostic Criteria: these interviews are tailored to cover diagnostic criteria in the official terminologies; for example the Diagnostic Interview for Children and Adolescents (DICA).

4. Self-Reports, Peer Reports, Reports of Significant Others: the Inventory of Anger self-report was designed with a fourth grade reading level in order to address the reading problems common among Conduct Disorder children. Peer reports involving children assessing their peers' behaviour problems have been shown to be accurate indicators of peer aggression (Coie & Dodge, 1983). Reports by significant others, commonly parents, usually correlate with clinical judgments of child dysfunction (Kazdin, 1987).

In order to gather information on a child, clinicians typically rely on a carefully drawn history based on material gathered from the child, the parents and the child's teacher. Many will do a family assessment to better understand the problems that may exist between children and their parents.

There are no serious diagnostic problems in cases where

antisocial behaviour began at an early age, persisted and became more serious with age. After an individual and family assessment, the diagnosis of Conduct Disorder is usually quite clear. However, when antisocial behaviour begins in late latency or early adolescence, usually in reaction to an identifiable psychosocial stressor, Adjustment Disorder with disturbance of conduct becomes an important differential diagnosis. An adolescent who starts stealing after his/her parents separate with no past history of antisocial behaviour usually responds well to short term therapy with excellent prognosis. In contrast, the child with an early history of antisocial behaviour usually requires long and intensive treatment with guarded prognosis. As the prognosis of Adjustment Disorder is much better than that of Conduct Disorder, it is important to distinguish the two.

COURSE OF CONDUCT DISORDER

The course of Conduct Disorder from early childhood onward reveals that aggressiveness is the most stable of all early detectable personality characteristics (Loeber, 1982). Robins & Earls (1986:76-77) point out that serious childhood behaviour problems

usually come to public attention in first school years, and are

> manifested by extreme resistance to adult authority, fighting, stealing, lying, truancy, and poor academic success despite normal intelligence...It becomes obvious that many of these children have had problems during the years before entering school.

It has also been noted that late onset appears to indicate a more gentle course of the disorder. However, this could be because late onset means there is a shorter time span to develop multiple symptoms after the first symptom appears (Robins, in press).

The natural course of Conduct Disorder has not been carefully studied. How the child showing aggressive behaviour in early years develops into a Conduct Disordered adolescent and into an antisocial adult is not clearly understood. One reason for this is that Conduct Disorder may stem from very early behaviour patterns. Often, Conduct Disorder children are described as having been difficult and irritable infants.

A twenty-five year follow-up of antisocial behaviour (Robins, 1966) found that aggressive behaviour more than any other tends to persist once established. In his review, Olweus (1979) found that a great degree of stability exists in the area of aggression. The stability is not much less than that found in the field of intelligence. Olweus claims that this finding is worthy of notice since the stability

of behaviours associated with intelligence and cognitive processes have been regarded as impressive and indicative of "genuine continuity". It appears that once aggression becomes a way of life, the child will express aggression differently at different stages of development. A study of 2600 children across the age span of 4 to 16 years (Achenbach & Edelbrock, 1981) indicated that symptoms of Conduct Disorder reported by mothers varied symptomatically by the ages of the children. In the youngest group, parents found children to be argumentative, stubborn and prone to tantrums while older children had oppositional behaviours, followed by fire-setting and stealing, and finally truancy, vandalism and substance abuse. Although the symptoms of antisocial behaviour evolve from tantrums to vandalism, they nonetheless remain antisocial. In his review of antisocial and developmental behaviour, Loeber (1982) came to similar conclusions. He determined that four factors were predictive of chronic delinquency: the frequency, the age, the variety, and the presence of antisocial behaviour in more than one setting. Therefore the child who is frequently antisocial at a very early age and who commits a variety of antisocial acts in different settings is the most likely candidate for chronic delinquency.

Which antisocial children are candidates for Conduct Disorder in adolescence and antisocial personality in adulthood? Robins et al. (in press) found that besides the number of symptoms, the critical determining variable is the age at which the Conduct Disorder symptoms first appeared. The earlier the age the greater the likelihood of antisocial behaviour being present in adulthood.

Specifically, a large study assessing antisocial personality determined that of those who had 5 to 7 symptoms of Conduct Disorder, before 6 years of age, 24 percent developed antisocial personality. In contrast, 16 percent of those whose symptoms first appeared between 6 to 12 years of age developed antisocial personality. Finally, this percentage drops to 10 percent when Conduct Disorder symptoms first appeared after the age of 12 (Robins et al., in press).

This supports most clinicians' impressions that there is a greater success in treating Conduct Disorder when symptoms first appear in adolescence. Conduct Disordered youth can be divided into three prognostic groups based on when symptoms first appeared; the best prognosis is for those whose symptoms first appeared at 12 years of age or later, the worst prognosis is for

those whose symptoms appeared before age 6, and a guarded prognosis is for those whose symptoms appear between the ages of 6 and 12 years.

It is not clear what happens to those with Conduct Disorder who do not go on to develop antisocial personality. There is some indication that many become substance abusers, as there seems to be a strong association between Conduct Disorder and substance abuse (Hesselbrock, 1986). There also appears to be an association between Conduct Disorder and later psychiatric disorders such as mania, schizophrenia, and obsessive compulsive disorder (Robins, in press). Besides predicting psychiatric disorders, Conduct Disorder also heralds a poor quality of adult life in other ways. An 18 year follow-up of Swedish children who were on probation for antisocial behaviour indicates a high, primarily violent death rate (Rydelius, 1988). Conduct Disorder also predicts school dropout, unemployment, financial dependency, poor interpersonal relationships and marital conflict (Robins, in press).

TREATMENT

The following review includes many studies based on delinquent populations, who may or may not have met the

diagnostic criteria of Conduct Disorder.

In the past there has been ongoing controversy concerning the success of treatment. Some reviews concluded that "nothing works" (Martinson, 1974). Others insisted that some techniques are remarkably successful (Ross & Gendreau, 1980). Who is to be believed? Were the two reviews using the same studies, and if so, why did they draw different conclusions? There was no way to replicate the reviews. In recent years there have been reports of meta-analysis of the treatment literature. Meta-analysis standardizes and interprets the findings of diverse studies in an objective and verifiable manner. This makes the replication of the review possible.

The application of meta-analysis has not eliminated the controversy. Genevie (1986) in his meta-analysis of the literature, concluded that effective programs were those that were relatively short-term and had practical goals. These programs provided job training and basic skills training, job placement and financial assistance after release. Garrett's (1985) meta-analysis of the review pointed out the effectiveness of such treatments as family therapy, cognitive behavioural therapy and contingency

management. Whitehead and Lab (1989) challenged all the above conclusions after their meta-analysis, and asserted that correctional treatment programs, including behavioural were ineffective, because they appeared to be successful only in outcome but not in reducing recidivism. So the controversy goes on.

In spite of the controversy in the field, it is possible to develop an understanding of the literature in this area. Studies published in the last thirty-five years can be broken into two periods, studies up to 1980 which primarily reported negative results and studies since 1980, where some promising and successful new approaches have been reported.

Review of Studies: 1955 - 1980

Romig (1978) in an extensive review of the literature on the rehabilitation of juvenile delinquents reported the rates of success of different treatment approaches in use. He included in his review only those studies which had a control group and used behavioural criteria for determining improvement. The conclusions of his review as it relates to each treatment approach are outlined below.

a) **Case work** typically involves a definition of the problem, recommendations and direct service. Service is client system

oriented, which perceives adolescents' problems as part of their personality as well as part of their relationships with significant others. In a review of ten studies involving case work not one study reported improvement (Romig, 1978).

b) **Individual psychotherapy** has not been a success with delinquents except with those who were "amenable" (Levitt, 1957). This finding is not surprising since psychotherapy is dependant on the motivation and cooperation of the client. As most Conduct Disorder symptoms are ego syntonic, there is no desire to change. In a review of ten studies (Romig, 1978), psychotherapy as a treatment was successful in only two studies.

c) The results of the application of **behaviour modification** were varied. Romig (1978) found that this treatment worked only when the behaviour to be changed was specific and behaviourally simple. Thus, it may be possible to modify a target behaviour, but not affect the recidivism rate or overall delinquency (Jesness et al., 1975). In a review of fourteen studies, eight reported improvement (Romig, 1978).

d) **Group counselling** does not appear to be a very effective treatment approach as only one-third (9 out of 27) of the studies

surveyed by Romig (1978) described positive results.

e) **Family therapy** as an approach was found to be no more successful. In a review of twelve studies four reported improvement (Romig, 1978). However it was reported by Alexander and Parson (1973) that success of family therapy depended upon the type of family therapy. Some types reported better results than others.

f) Romig (1978) reviewed eight **milieu therapy programs** and four programs using the **therapeutic community** approach. He found that only one study involving milieu therapy and none of the four studies involving therapeutic community approach reported positive results.

In summary, Romig's review of the literature indicated that such traditional treatments as case work, individual psychotherapy, group psychotherapy, milieu therapy, and therapeutic community therapy, are no more beneficial than no treatment. Behaviour therapy and family therapy are successful only with reservations. Behaviour therapy may change the target behaviour, but it does not reduce the rate of recidivism. The success of family therapy seems to depend upon the type of family therapy. Some types of family therapy such as behavioural systemic, are more successful than

others.

Review of Studies: 1980 - present

Basta and Davidson (1988) conducted a computer-data-based search of the literature published from 1980 to 1987 on the treatment of adjudicated juvenile offenders. They found that in treatment programs without a follow-up component, 26 out of the 37 (78 percent) reported positive results in some areas. However, in treatment programs that had a follow-up based on rates of recidivism, only 16 out of the 37 (43 percent) had positive results. The fact that improvement does not last long enough to reduce the rate of recidivism seems to be biggest challenge. With most treatments, including behavioural, it is on follow-up that the results become disappointing.

In the last ten years many new and promising approaches have appeared which seem to make a difference in the outcome.

Promising Treatment Strategies

a) For **Behavioural systemic family therapy**, in which principles of systemic and behavioural approaches are combined, Gordon et al. (1986) found a recidivism rate of 11 percent after a two and half year follow-up compared to the control group, where the recidivism

rate was as high as sixty-seven percent. This rate of improvement is very impressive and is an advancement on the results of Alexander and Parson's (1973) study which also reported positive results using this approach. Thus it seems that family therapy as an approach is useful, but the critical factor is the type of the family therapy.

b) There have been reports of success with a variety of **cognitive behavioural programs**. Gordon and Arbuthnot (1987) found in their study of aggressive school-aged children (Grade 7 - 10), that socio-moral reasoning resulted in improvements in moral reasoning, the number of police and court contacts and the frequency of disciplinary referrals. Moreover, improvement continued for one year after the termination of treatment.

c) Reporting on **"Think Aloud"**, a program that relies on modeling and rehearsal of cognitive strategies, Camp and Bash (1981) found that teachers' ratings of aggressive boys improved.

d) Broad-based interventions address dysfunctional behaviour within the context of the individual, his/her family and peer group as well as within the systems in which the individual is involved. Henggeler et al. (1986) evaluated a **family-ecological systems**

approach which offered multiple interventions in response to social, cognitive and interpersonal functioning. While it appeared superior to conventional treatments, it provided no long-term follow-up.

e) Mills and Walter (1979) demonstrated that **helping the offenders to get a job and keep it** prevents them from further arrests. This success could be due to factors such as working with employers, the shaping of pro-employment behaviour in the adolescent and the pay packet at the end of week.

f) In **Parent Management Training**, parents are trained to develop prosocial behaviour in their children. This approach has been effective with conduct problem children and positive treatment effects have been maintained for longer than one year (Patterson, 1982).

g) **Teaching Cognitive Problem-Solving Skills** to children is a promising psychosocial approach since maladaptive cognitive processes are related to antisocial behaviour. In one study, interpersonal problem-solving skills training was delivered to both the offender and the parents resulting in a recidivism rate of approximately 24 percent for the experimental group and 43 percent for the control group (Collingwood & Genthner, 1980).

h) **Community-Based Interventions** aimed at developing prosocial behaviour and better peer relations are a viable alternative to individual treatment. Such interventions provide care within the community, relying on programs already in existence. While certain questions still need to be addressed, Feldman et al. (1983) found that community-based interventions can be a successful approach in reducing antisocial behaviour in youth.

i) **Anger Replacement Training** is a multi-modal, psychoeducational intervention for assaultive, hostile adolescents. As a result of this training, the number and intensity of antisocial behavioural incidents decreased significantly. It is not established whether the training, affects the behaviour of the youth once they leave the institution (Glick & Goldstein, 1987).

Critical Issues in Treatment Planning

As a result of the above review it is possible to determine which type of Conduct Disordered youth should receive what type of treatment. It is also possible to determine which factors will enhance the effectiveness of a treatment, and which will retard it. The following is a list of issues that should be considered in planning treatment of Conduct Disordered youth.

1. The failure of treatments on follow-up may indicate a major flaw in the way the disorder is conceptualized. Conduct Disorder, particularly especially "hard core" Conduct Disorder where antisocial behaviour first appeared before the age of six and persisted, should not be seen as a disorder but as a lifelong disability. Therefore the medical model of illness and cure should not be applied. Instead, hard core Conduct Disorder should be more comparable to such disabilities as epilepsy, diabetes or mental retardation, which require lifelong support. Wolf et al. (1987) advocating this concept suggested that support to the family and the youth should be long-term and not confined to adolescent years. If "hard core" Conduct Disorder is viewed as a disability, from which one does not recover, but with support learns to live with without developing major symptomology, then the problem of treatment failure on follow-up disappear. The treatment and support never stop.

2. Presence of the family and its willingness to cooperate, are important factors without which such effective treatments as behavioural systemic family therapy cannot be applied. In addition, the presence of a caring family can become an ally of the therapist, enhance the efforts, and make the treatment more likely to succeed

regardless of the approach.

3. Cognitive and intellectual abilities should also be considered in deciding the treatment approach. Certain approaches which require conceptualization, may not work, if the intellectual abilities are limited. For these youth, job training and finding and keeping a job may be a more useful approach. Regardless of the approach, high intelligence seems to be a positive factor effecting treatment outcome.

4. The success of a treatment approach is also dependant on the presence or absence of additional problems besides antisocial behaviour. The presence of such problems as learning disability, impulsivity and hyperactivity increases the chances of failure, as it increases the difficulties in treatment regardless of the approach. Youth with multiple disabilities require a well-structured program including many approaches, as no single approach is able to meet all their needs. They may require medication for hyperactivity, an anger reduction group or "think aloud" program for impulsivity, and special educational help for their learning disability.

5. In planning the treatment, attention must be paid to the results of evaluative research. Those treatments which have proven

to be ineffective with Conduct Disordered youth should be avoided. Unfortunately treatments such as case work and individual psychotherapy which have been shown to be ineffective, continue to be used for this population, with poor results.

6. Given an array of effective treatments, it should be possible to select one or more treatments which will meet the needs of a particular Conduct Disordered youth. The suitability of a treatment could affect the treatment outcome.

Thus, treatment effectiveness depends not only on the approach, but also on intrinsic and extrinsic factors related to the youth. Given the controversy, and the present state of the knowledge, it will be futile to apply one approach to all Conduct Disorders. It seems reasonable to be aware of all approaches which have been proven to be effective, and then apply one or more depending on the needs of the youth.

PREVENTION

There have been no serious efforts in preventing the development of Conduct Disorder. Until recently it was not clearly understood why some children grow up to be violent. Thus, it has been difficult to develop plans to prevent the development of this

behaviour. In recent years, through longitudinal prospective studies, factors which contribute towards the development of antisocial behaviour have been identified. In the following account, the factors which promote and which prevent the development of antisocial behaviour will be discussed. There will also be brief description of prevention programs which have shown promise, in preventing the children from growing up to be violent.

Risk Factors

Risk factors are those factors that if present, increase the probability of a child developing an emotional or behavioural disorder (Garmezy, 1983). In the 1983 Ontario Child Health Study, Offord et al. (1988) found that the risk factors associated with Conduct Disorder were the following: being male and the eldest child, being from a large sibship (four or more siblings) and belonging to a dysfunctional family. Early onset of Conduct Disorder was associated with families with an income of less than $10,000.

The literature on the risk factors of Conduct Disorder (Kazdin, 1987; Offord, 1989; Rae-Grant, 1989) identified a number of individual and social factors. These include the following:

-Family Factors such as psychiatric problems in parents, criminality in fathers, family dysfunction and inconsistent parenting;

-Child Factors such as male gender, biological vulnerability, difficult temperament, early behavioural problems and school failure;

-Community Factors such as subsidized housing, delinquent peer group and poor school environment.

Lewis et al. (1989) claims that although external factors, such as growing up in a violent family, and internal factors, such as psychiatric, neurological and cognitive disabilities, are all risk factors, it is the combination of internal and external factors which leads to serious and extreme aggression in adults.

Protective Factors

Protective factors are those variables which serve to protect individuals from an environment which places them at high risk for disorder (Rutter, 1985). It was realized that some children, despite being exposed to high risk backgrounds, have good psychological outcomes. Through the study of the so called "invulnerable" children, a list of protective factors has been developed. These

factors have been identified in the literature by Offord (1989) and are as follows:

-Characteristics of the Social Group - there is a suggestion that voluntary change to a less deviant peer group may prevent antisocial behaviour;

-Employment - employment may deter antisocial behaviour as unemployment is associated with delinquency;

-Change of Circumstances - improvement in social circumstances may lead to a reduction in antisocial behaviour;

-Good Relationship - a close, warm and confiding relationship with one parent or another adult reduces the likelihood of developing Conduct Disorder;

-Compensatory Good Experiences - good experiences such as school competence or skill development have been shown to reduce antisocial behaviour;

-Coping Mechanisms - improving coping through training programs has yet to show improvements in adjustment.

Recognition of risk and protective factors make it possible to develop interventions for children who are at risk, so that they do not develop undesirable and self-destructive behaviours.

Interventions which aim in this direction do not have to be specifically targeted at Conduct Disorder. All interventions which improve the interaction of the child with the environment will ultimately reduce the incidence of Conduct Disorder. Thus projects which reduce biological vulnerability, those which improve child parent relationships, those which improve interpersonal cognitive problem solving skills and those which improve the environment (e.g. schools) can both increase academic competence and reduce antisocial behaviour. The object of those interventions has to be to break the causal chain which ultimately leads to Conduct Disorder. There are now reports that programs of this nature have been shown to be successful in protecting children. These prevention programs, though not specifically designed for reducing the incidence of Conduct Disorder, were aimed at children who were considered at risk.

The success of these programs provides encouragement that in future, children at risk could be provided with support, so that high incidence of behavioural disorders such as Conduct Disorder could be reduced. It is clear that such programs have to be specifically designed for different age groups: pre-natal and infancy, pre-school

and school-age children. Some of the principles involved in developing such programs are clearly outlined (Ministry of Community & Social Services, 1989).

The following prevention programs, reported by MacKillop and Clarke (1989), describe projects that have been successful in helping high-risk children.

1. The Syracuse University Family Development Research Program

This program provided five years of support to deprived families, particularly to those headed by black single mothers, in areas such as child-rearing, family relations, and functioning in the community. On follow-up, program children were involved in fewer and less severe offences, had improved self-esteem and for girls, improved school performance.

2. The Perry Preschool Project

Black children from low income homes received a daily preschool program and weekly home visits over a two-year period. Periodic follow-ups were made until the children reached the age of 19. These children made significant gains in school motivation, achievement and behaviour, and at age 19 had a better educational

level, better employment history and less criminal involvement than a control group.

3. PALS (participate and learn skills), reported by Jones and Offord (1989), offered nonschool skills development to children 5 to 15 years of age who lived in publicly supported housing. Targeted children committed fewer serious offences and many fewer security violations.

Fleisher et al. (1987) reported on a thirteen-week school intervention program consisting of social skills training and group counselling for high school students. The results were that the program lessened anger and violent action, improved school performance and reduced delinquent gang involvement.

Conduct Disorder:

Relevant Issues & Recommendations

in

Treatment, Prevention, and Research

(Based on the presentations made by

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CONDUCT DISORDER RETREAT

What can be done to improve treatment strategies, enrich and extend prevention programs and encourage more research in the area of Conduct Disorder? The retreat **Youth with Conduct Disorder: What is to Be Done?** was organized to bring together researchers and clinicians whose achievements were primarily in the area of Conduct Disorder. The seventeen participants were asked to define the steps needed to improve treatment quality, develop a better understanding of the disorder and reduce the incidence of Conduct Disorder. They focused their attentions on treatment, prevention and research. Two and one-half days of brainstorming resulted in the following insights and recommendations.

RELEVANT ISSUES IN TREATMENT

Conduct Disorder is one of the most difficult disorders to treat in child psychiatry. These youth are managed in a variety of settings using many different approaches. Although there are indications that cognitive, behavioural, family and employment approaches can be fruitful, traditional treatments such as individual psychotherapy are still frequently employed. There is no attempt

at the government, agency or professional level to develop a consensus about the best treatment strategies for these youth. Evaluations of the treatments being administered are rare and there is a lack of long term follow-up in treatment. Consequently, it is not known whether youth who get treatment do better than those who refuse treatment or those who are discharged due to difficult behaviour.

Despite the fact that Conduct Disordered youth present the greatest challenge in treatment, they are frequently handled by the least-trained staff. In most settings the front-line workers have very little understanding of the disorder, its nature, and course or the treatment programs used. Frequently, they are disappointed and discouraged by the lack of progress made by these youth. This can lead to low morale and rapid staff turnover, which further affects program effectiveness.

Treatment is also hindered by setting. In many cases Conduct Disordered youth are treated in residential settings alongside youth suffering from a variety of other disorders. This often results in Conduct Disordered youth mistreating psychotic, depressed or dual diagnosis residents, disrupting programs and demanding an

inequitable amount of attention from the staff.

There are further problems plaguing treatment delivery. Most Conduct Disordered youth, especially those who had early onset, require long-term treatment. Most programs and agencies only offer short-term commitments. This results in youth being transferred from one agency to another. These transitions sometimes lead to setbacks in the progress achieved during treatment.

TREATMENT RECOMMENDATIONS

- A meta-analysis review of the literature should be done to determine the most effective treatment strategies for children before the first grade, children from age 6 - 12 and children from age 12 - 18.
- As a result of a meta-analysis review of the literature, information regarding what is known to be effective should be available to all programs treating Conduct Disorder. There should be an expectation that those approaches which have been proven to be effective will be used.
- A provincial resource and advocacy centre should be established to provide consultation, information and education

to centres involved in the treatment of Conduct Disorder. This resource centre would have experts from a variety of settings available for support, consultation to cases, programs and staff development. It would also promote communication and coordination between centres.

- Children who show persistent aggressive behaviour at an early age should be monitored by an agency on a long-term basis. This agency then coordinates and ensures that the needs of the child and family are met as the child grows up. This arrangement will provide continuity and could prevent multiple agency involvement, multiple assessments, and treatment disruptions.
- For hard-core Conduct Disordered youth (where persistent antisocial behaviour started early in life, and became more serious over time with or without treatment) there should be specialized programs which provide intensive (including residential) and long-term (until adulthood) treatment. Every effort should be made to coordinate with adult services so that there is no break in care. These units will use state of the art approaches with built-in evaluation. Staff would be

specifically trained to work with Conduct Disordered youth. These programs will be affiliated with universities so that teaching and research are integrated.

RELEVANT ISSUES IN PREVENTION

In view of the high cost of prolonged treatment and its relative ineffectiveness, it would be natural to look at prevention as an alternative. Yet very little has been done in the area of prevention. There are two major reasons for it. The first reason is that until recently there was a lack of understanding as to why some children grow up to be antisocial. The second reason is that any serious attempt at prevention entailing large populations involves government intervention and extra expenditures, with results appearing decades later. Politically and practically, this is not a very appetizing recipe.

At the present time, however, these reasons should not be major obstacles. As a result of many careful longitudinal studies, it is becoming clear why some children grow up to be violent. The risk factors which promote the development of violent behaviour are more clearly understood. Moreover, the factors which work against the development of antisocial behaviour have now been

identified. Given the above, it is becoming feasible to develop programs aimed at populations at risk. In fact many such program have been tried and the results are encouraging.

The growing public alarm at the rising incidence of violence among youth makes such efforts politically acceptable. In fact, there is increasing concern and demand for action. There are two possible, though not necessarily exclusive, approaches to reducing violence in youth. One is to spend more money on law enforcement and containment. The other is to take the course of prevention by identifying populations at risk and ensuring that children receive the care, attention and discipline that they need to grow up right.

There are some positive signs that governments are considering prevention strategies as a solution to increasing violence in society (Ministry of Community & Social Services, 1989). It would be both humane and economically wise to choose the prevention route. The following recommendations offer possible courses to take in prevention.

PREVENTION RECOMMENDATIONS

- The relevant government ministries should support the idea

that 5 percent of every service plan should be devoted to primary prevention. This could be pooled across agencies in each area.

- An integrated demonstration project should be developed with the knowledge and awareness of successful prevention programs in existence.

The following age-specific programs could be implemented.

- For children 0-6 years of age, mother's allowance could be tied to a prenatal and postnatal program. This program would have public health nurses providing in home services as well as clinics offering health and developmental checkups. Day care, parent support groups and education would also be available.
- In the 6-12 year age group, recreation programs should be linked with schools and/or housing projects in high risk areas, and include options such as meal programs and after school programs for school work and recreation.
- Summer programs should be available for youth. Businesses could be encouraged to donate uniforms and equipment while the police might be involved in some aspect of the program,

such as being team captains.

- A modified Fresh Air Fund to link urban high risk kids with country families for summer holidays might be established.
- Parents could be encouraged to attend parent training programs.
- Training for professionals must include normal and abnormal child development issues as well as cultural issues.
- Parents should be taught how best to use the resources available to them.
- Schools should provide placement opportunities for those training in the following disciplines: child psychology, psychiatry, social work and child and youth care work.

RELEVANT ISSUES IN RESEARCH

There have been suggestions that the lack of success in treatment is evidence of intractability of criminal behaviour. In fact, the inability to reduce violent behaviour in youth may be partly the result of limited expenditures being spent on research in this highly complex field.

While the lack of success in treatment in disorders such as cancer and cystic fibrosis in the past has increased the commitment

and expenditure on research, no similar response is seen with Conduct Disorder. In fact, a lack of success in treatment has been used as an argument against increased spending. Given the high incidence of the disorder, the cost to the community and the family suffering that sometimes continues from one generation to the next, Conduct Disorder necessitates a high priority for research dollars.

In a recent survey conducted by I.A.V.Y., it was determined that research in this area conducted by children's mental health centres in the Province of Ontario was practically non-existent. The meagre amount of money spent on research may account for why key issues in the classification, diagnosis and treatment of Conduct Disorder are yet to be defined. Large, multi-centre studies with long term follow-up can only be undertaken when there is an increased commitment to promoting research in centres involved in treatment. Unlike those afflicted with debilitating disorders, most Conduct Disordered youth could become successful members of the community if there were better treatments and a determination to implement them.

RESEARCH RECOMMENDATIONS

- The outcomes of long-term interventions for Conduct

Disordered youth need to be evaluated. The issues to be worked out include how to describe the youth, how to track them over time and which outcome measures to use.

- The characteristics of children whose behaviour can be suppressed during intervention need to be identified. The effective approaches must be carefully observed in order to generate hypotheses regarding successful treatment interventions.
- The early signs of Conduct Disorder need to be determined, with differentiation between risk factors and early symptoms.
- The skills needed by children to get ahead in school, succeed with peers, develop language and solve problems must be identified.
- A follow-up of adolescents who refuse treatment against advice and are released by review boards needs to be done. The question of how treated children manage in relation to those who refuse treatment needs to be addressed.
- The budget allocations of funding agencies for research on children with Conduct Disorder need to be increased.
- Multi-disciplinary and multi-centre research must be supported.

- Agencies need to make available seed money for pilot projects.
- Academic settings should be lobbied to support the placement of researchers in clinical settings. Researchers must do some clinical work in order to understand clinical orientation.
- A consortium of agencies could be established to provide a multi-centre research staff.
- Research training should be introduced into mental health professional training.

CONCLUSIONS

There has been a dramatic increase in the violent acts committed by youth. Between 1962 and 1987 there was a tenfold increase in the number of youth under the age of 18 charged with violent crimes. This increase has caught the attention of the public and the governments. There are persistent demands for action. Of course an increase of this magnitude deserves action. The important question is, what direction will this action take? A very convincing case is being made that what is required are tough sentences, more police and more jails. The fact that harsh punishments have proven to be ineffective in reducing rates of recidivism does not seem to matter. What is not asked is, why have our youth become more violent in recent years? What are the factors in the family and the society which promote the development of aggressive behaviour in a child? How can we stop the cycle of a difficult child growing up into a Conduct Disorder and how can we stop this adolescent growing into antisocial personality disorder? We may not have all the answers, but let us ask the right questions. For those questions which cannot be

answered today, let us provide enough money for research so that they can be answered one day in the future. This is what we do when we face similar problems in other medical disorders. Why not use a similar strategy for Conduct Disorder? Let us find ways of preventing children from being violent, and for those who are violent, let us find more effective ways of helping them. A disorder affecting so many youth, causing so much misery, and costing so much money deserves greater attention from those who determine priorities.

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